STATE OF DELAWARE
FEDERAL FOOD COMMODITIES PROGRAM
ELIGIBILITY TO TAKE FOOD HOME
TEFAP Agency_____

Name: _____ Number of People in Household: _____

Address: _____

This table shows an annual gross income for each family size. If your household income is at or below the income listed for the number of people in your household, you are eligible to receive food

Household Size	Annual Income	Monthly Income	Weekly Income
1	**20,036**	**1,670**	**386**
2	**26,955**	**2,247**	**519**
3	**33,874**	**2,823**	**652**
4	**40,793**	**3,400**	**785**
5	**47,712**	**3,976**	**918**
6	**54,631**	**4,553**	**1,051**
7	**61,550**	**5,130**	**1,184**
8	**68,469**	**5,706**	**1,317**
For each additional member of family add:	**+6,919**	**+577**	**+134**

( ) Income is less than listed on above income scale.

You are also eligible to receive food from TEFAP if your household participates in any of the following programs. If you participate in one of these programs, please place a check next to the program.

_____ Food Stamps _____ AFDC _____ Medicaid

_____ GA _____ SSI

Please read the following statement carefully. Then sign the form and write in today's date.

I certify that my annual gross income is at or below the income listed on this form for households with the same number of people as my household, OR that my household participates in the program that I have checked on this form. I also certify that, as of today, my household lives in the area served by the Delaware Emergency Food Assistance Program. This certification form is being completed in connection with the receipt of Federal assistance. Program officials may verify what I have certified to be true. I understand that making a false certification may result in having to pay the State for the value of the food improperly issued to me and may subject me to criminal prosecution under State and Federal law.

_____ _____

(Signature) (Date)

_____ _____

(Proxy Signature) (Date)

Proxy Address

_____

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